EMSAAC

The Emergency Medical Services
Administrator's Association of California

Present an

ISSUE PAPER

Regarding the

Health Care Financing Administration

Negotiated Rule-making Process for the
establishment of an Ambulance Fee Schedule

EMSAAC POSITION PAPER

Negotiated Rule-making for
Medicare Ambulance Fee Schedule
September, 1998

BACKGROUND

The Emergency Medical Services Administrators Association of California (EMSAAC) represents thirty two (32) local emergency medical services agency administrators in California which, in turn, represent all 58 counties and 49 Congressional Districts of the State of California. In California, the Local EMS Agency is charged with planning, implementing and overseeing the delivery of emergency medical services and administering the state's interests at the local level.

The intent of this document is to provide our organization's views regarding the development of a Medicare ambulance fee schedule. Our perspective is one of a systems approach - that is, we have considered all aspects of the pre-hospital medical system in the deliberation and recommendations contained in this Position Paper. It is vitally important to us as EMS system administrators that the eventual fee schedule not result in a negative impact on ambulance providers which, in turn, would reduce access to necessary emergency medical services for Medicare beneficiaries. We believe ultimately the fee schedule must be flexible enough to take into consideration the factors enumerated in this Position Paper.

One of our responsibilities as local EMS agency administrators is to contract for ambulance services to serve the population within, and the visitors to our jurisdiction. These contracts are typically performance-based and require strict operational and medical standards of service. Compliance by the ambulance services with these performance-based standards has a direct impact on their cost of operations with regard to personnel requirements, response time compliance, standards of care, total number of ambulances available for service, etc. While the local EMS agency endeavors to contract for reasonable standards, any substantial relaxation of these contract requirements could erode the provisions of rapid emergency medical treatment and place the public in jeopardy.

As a major player in health care reimbursement, alterations in the reimbursement strategy used by Medicare would have a dramatic impact on ambulance operations. The preservation of the health care safety net for millions of Medicare beneficiaries depends on the diligent and thoughtful structuring of a fee schedule. While the Medicare population represents approximately 12% of the total population in California, they typically account for between 30% to 40% of ambulance transports.

We believe that a fee schedule must take into consideration the many factors that influence the cost of providing quality ambulance services to our communities. Without these considerations, a fee schedule could have a devastating effect on our ambulance providers' ability to meet their contractual obligations and our ability to protect the health and safety of our citizens. This is particularly worrisome as Medicare beneficiaries are such a large percentage of the population served, and their percentage of the population will increase in the future. Substantial reductions in reimbursement may place a burden on counties to provide additional financial subsidy for

ambulance operations or, alternately, cause us to reduce the level of service provided if such additional funding is unavailable. Discretionary revenue is scarce at the county level, and is already being stretched maximally to meet local service needs.

For these reasons, the following document presents discussion points and recommendations of the EMS Administrator's Association of California regarding the establishment of an ambulance fee schedule for Medicare beneficiaries by the Health Care Financing Administration.

ISSUE 1 - SHOULD HCFA ESTABLISH A FEE SCHEDULE THAT INCLUDES BOTH ADVANCED LIFE SUPPORT (ALS) AND BASIC LIFE SUPPORT (BLS) SERVICES?

Response: Yes, however we believe the basic structuring for ALS and BLS Medicare payments should be changed.

Discussion: Specifically, the two major categories for reimbursement should be emergency and non-emergency, rather than ALS and BLS. Definitions should be developed for these two major categories that reflect the type of response, and/or the systems demand for the type of response provided. There are substantive differences between the cost of providing emergency and non-emergency services, which include but are not limited to personnel, equipment, training, insurance, medications/supplies, quality review processes and continuing medical education. Any fee schedule that is cost-based must recognize and differentiate fees for these different levels of service.

There has been an on-going debate whether Medicare should reimburse providers for the actual level of care administered (ALS or BLS interventions) to a patient, or whether providers should be paid for the level of service they are required to provide in response to an emergency or non-emergency call. For the sake of this discussion, it is assumed that HCFA will use cost-based data for the establishment of the Medicare ambulance fee schedule which includes both the level of service provided and the category of care given to the patient.

The majority of EMS systems (with the exception of very rural areas) are all ALS, and require ambulance providers to respond ALS (paramedic) ambulances for medical emergencies. Regardless of the type of interventions actually performed on the patient, these ambulance providers have already incurred the cost of maintaining ALS service on a 24 hour per day, seven day a week basis. The cost for the supplies used in actual ALS interventions is not significant when compared to the on-going cost of maintaining and providing ALS system readiness. For this reason, EMSAAC strongly recommends that HCFA establish a fee schedule that recognizes the baseline fixed costs of providing this valuable state of readiness to Medicare beneficiaries and reimburses providers at the level of service provided to the patient for emergency (and non-emergency) responses, and not the type of medical interventions performed.

Based on the above, we believe the fee schedule should include a breakdown of the fee payment structure as shown on the matrix below that would allow for several categories of payment under both emergency and non-emergency. By doing so, and basically considering ALS as paramedic level of care and BLS as EMT level of care; and including other fee payment categories such as air ambulance and critical care transports, the reimbursement categories would coincide with the actual provision of prehospital ambulance services to Medicare beneficiaries in the various EMS systems.

EMSAAC PROPOSED FEE SCHEDULE PAYMENT CATEGORY MATRIX

LEVEL /CATEGORY (Based on Medical Necessity)	Emergency	Non-emergency
Wheel Chair/gurney Van*	N/A	Yes
EMT (BLS) ambulance	Yes (for systems with only BLS)	Yes
Paramedic (ALS) ambulance	Yes	Yes (needed for systems requiring ALS only)
Critical Care Transport ambulance	Yes	Yes
Air Ambulance	Yes	Yes

*not currently a covered benefit.

Once definitions for these categories are established, HCFA should simplify and streamline the claims reimbursement process and end the practice of retrospective denial, if the claim submission meets the definition. Frequent, lengthy claims disputes unnecessarily add to the costs of providing the service.

Recommendation: HCFA should establish fees for both emergency and non-emergency levels of services, and establish payment categories for claims within each of the designated levels of service and care provided, not the type of specific medical intervention performed. Once the claim is qualified based on the definition, it should be paid without delay or a requirement for further justification.

ISSUE 2 - SHOULD HCFA 'BUNDLE' ALL CHARGES, BUNDLE MOST CHARGES WITH SOME EXCEPTIONS OR HAVE A 'LAUNDRY LIST' OF CHARGES WITHIN THE FEE SCHEDULE?

Response: HCFA should bundle the majority of charges, with the exception of mileage and pharmaceuticals, due to the regional variation that exists for the cost of these items. HCFA should establish adjusting factors to address such issues as service in rural areas, emergency vs. non-emergency service, regional cost of living differences and performance-based contractual costs.

Discussion: There are numerous arguments for all three propositions. We believe the option that best fits with the objective of HCFA to control the costs for ambulance reimbursement should be guided by simplicity. The more complex the process, the more likely there will be denials, disputes and the potential for abuse, all of which increase the costs to the participants and the system.

While simplicity is desirable, a fee without adjusting factors would place many providers and systems in jeopardy. Simplicity with a fair and reasonable approach to regional cost variation is desired. To that end, we recommend the following adjustment factors:

1. Emergency vs. Non-emergency

   Emergency (9-1-1 non-scheduled) calls require a degree of readiness and ambulance unit distribution that is not required in the non-emergency (scheduled or pre-scheduled) setting. The cost for additional, geographically balanced ambulances to ensure a rapid re-

sponse is considerable, and should be factored into the reimbursement equation. Additionally, there is greater risk for emergency responses and higher insurance premiums for emergency responders.

2. Rural Service Areas

Metropolitan areas, due to their relatively small geographic area, high population density, high call volume and short transport times lend themselves to highly efficient utilization of ambulance units (unit hour utilization or UHU). Just the opposite is found in the rural areas of the country. While it is not often possible to achieve the same response time standards in the rural areas that are possible in the metropolitan areas, we nonetheless push for as stringent of response time requirements as possible. To do so requires adequate numbers of units dispersed throughout the region. This is costly to the rural provider, effects efficiency and ultimately results in higher cost. One of the reasons for this is the longer 'time on task' found in rural areas. The much lower call volume of the rural areas will also increase the costs per unit.

We also believe it is critical for HCFA to consider redefining 'rural areas' in order to ensure that all low population density areas are included. Using Zip Code demographic information could be one of the determinants in defining rural areas. We recommend rural areas receive serious consideration for upward fee adjustments in the overall structure of the eventual fee schedule.

3. Performance-based Ambulance Contracts

Performance-based contracts typically require ambulance providers to meet a number of standards aimed at maximizing service delivery to the public. These standards include, but are not necessarily limited to: Response time requirements, staffing minimums, medication and equipment standards, rate regulation, unit hour utilization maximums, internal quality review procedures, vehicle maintenance standards, insurance requirements, dispatch center staffing and performance standards, etc. These standards are there to provide for the health and safety of the public and ensure consistency, standardization and quality assurance of the services provided.

Clearly, meeting such community standards increases the cost of providing services for the contractor, when compared to those providers that are not under such service contracts. We believe it to be reasonable and prudent to adjust the rate for ambulance services making this type of commitment to Medicare beneficiaries.

4. Regional Cost of Living Adjustment

Consideration should be given for differences in regional economic factors as well as regional medical/practice cost differences.

Recommendation: HCFA should establish a fee which bundles all charges except mileage and pharmaceuticals. In addition, HCFA should establish adjusting factors that address the issues of emergency vs. non-emergency, rural service areas, performance-based service and regional cost differences.

ISSUE 3 - SHOULD HCFA FACTOR INTO ITS RULE-MAKING PROCESS THE ISSUE OF THOSE AMBULANCE PROVIDERS THAT RECEIVE FINANCIAL SUBSIDY VS. THOSE THAT DO NOT?

Response: Yes

Discussion: In establishing an ambulance fee schedule, we believe it reasonable and prudent for HCFA to take tax subsidies paid to ambulance providers into consideration. Whether the tax support is in the form of direct tax-based operations (public service, fire based, etc.), tax subsidy from the local government or the establishment of a special tax district which provides subsidy to providers, a provider receiving tax support may have a financial advantage over those providers that receive no such tax support. Non-subsidized providers must rely completely on reimbursement to support their operations.

We also believe that the issue of subsidized vs. non-subsidized rates should be addressed through an adjusting factor. A subsidized provider would receive the base rate plus any other appropriate adjusting factors. A non-subsidized provider could receive the above plus an adjusting factor for its non-subsidized status.

Recommendation: HCFA should establish an adjusting factor for those providers that do not receive tax dollars to support their operations.

ISSUE 4 - HOW CAN HCFA QUANTIFY THE COST DIFFERENCE BETWEEN EMERGENCY AND NON-EMERGENCY SERVICES?

To meet the public's expectations for immediate, competent and efficient service during a medical emergency, emergency services require more manpower, additional units in readiness, a higher level of staffing per unit, a comprehensive communications system and a full compliment of emergency equipment. Non-emergency service, in contrast, requires little of the above and is less expensive to provide. Ambulance providers should be able to provide cost data to show the differences in providing emergency and non-emergency services.

ISSUE 5 - CAN "UNIT HOUR COST" CALCULATIONS BE USED TO DETERMINE THE COSTS ASSOCIATED WITH AMBULANCE SERVICES?

Response: No

Discussion: Unit hour costs (UHC) are calculated using a myriad of factors that vary extensively across the nation. As discussed previously, UHC for rural providers are typically much higher than for their metropolitan counterparts, and using UHC as a basis for a baseline fee would tend to penalize the rural provider. Due to the complexity and enormous variance of UHC nationwide, it is doubtful that a fair and/or useful fee schedule could be developed using UHC as the basis.

Recommendation: EMSAAC recommends that HCFA not utilize UHC as a basis for the development of a baseline fee schedule.

ISSUE 6 - WHAT DATA IS AVAILABLE AND HOW CAN HCFA OBTAIN AND USE IT IN ESTABLISHING A FEE SCHEDULE?

Response: The data collected by Local EMS Agencies would not be of significant use in establishing a fee schedule.

Discussion: EMS agencies typically collect a great deal of data regarding patient care information and performance standards compliance. However, we are of the opinion that this data would be of little use in determining costs for a fee schedule. Most private providers do not share their specific costs of providing service or reimbursement data with EMS agencies.

It is our understanding that the American Ambulance Association intends to use the Project Hope Center for Health Affairs to conduct a nationwide cost survey. We believe this represents a very credible process and perhaps a reasonable approach to obtain the actual cost of providing these services, as there is no other credible data on the issue, to our knowledge.

Recommendation: EMSAAC recommends that HCFA review the proposed Center for Health Affairs survey and, assuming that the methodology meets with their approval, use the nationwide survey data to establish the relative costs for service.

ISSUE 7 - WHAT PERCENTAGE OF BUSINESS IS REPRESENTED BY MEDICARE IN THE PREHOSPITAL SECTOR?

Response: Thirty to Forty Percent (30% to 40%)

Discussion: While the percent of business represented by Medicare will vary from area to area depending on the underlying demographics, a recent statewide survey of public and private providers in California resulted in an average of 35%. This is consistent with previous surveys nationwide which revealed Medicare percentages ranging from 30 – 40% of all ambulance business.

Medicare remains a major source of EMS reimbursement, and any substantive reduction in ambulance reimbursement from Medicare could have devastating consequences on the service delivery of EMS and the healthcare safety net for millions of Medicare beneficiaries. Great care must be taken to ensure that appropriate adjusting factors are built into any fee schedule to accommodate the cost differences outlined previously.

Important to this discussion of how Medicare payments affect the prehospital emergency medical systems is the review, denial and appeal processes. We believe it is critical for HCFA to ensure that claims for reimbursement be viewed only prospectively. That is, it seems reasonable to reimburse a provider for the dispatch response system that sends the responder and medical situation presented at the scene, which results in a particular level of care, transport, etc. It seems inherently unfair and unreasonable to deny claims based on a retrospective review of the patient's condition after the emergency team has been responded for the patient and incurred the costs associated with that response.

Recommendation: The process for reimbursing and paying claims should be based on the prospective analysis of the patient's medical condition - that which was presented to the medical dispatcher.

ISSUE 8 - ARE THERE OTHER AREAS THAT HCFA MIGHT EXPLORE THAT COULD RESULT IN AN OVERALL COST-SAVINGS?

Response: Yes

Discussion: Currently, Medicare does not pay for wheelchair or "litter/gurney vans," and it is arguable that many "non-emergency BLS ambulance" transports, currently paid for by Medicare, could qualify for transport at a lower litter/gurney car rate. While the number of these transports that are currently being paid by Medicare is unknown, it is an area of potential over expenditure and should be addressed.

It is also a concern that many elderly, informed patients need wheelchair and/or litter van service and currently have to pay for these services (or higher rates for BLS ambulance) with their fixed incomes. While they may not have an acute, previously undiagnosed condition, this does not alter the fact that such transports can be medically justified due to an existing condition, e.g. fractured hip, stroke, etc.

Recommendation: We recognize that creating newly covered benefits or payment categories is probably not within the scope of the negotiated rule-making proceedings for an ambulance fee schedule. However, we believe HCFA should explore the options addressed above at the earliest possible time.